

Surface Mining Control and Reclamation Act of 1977 to transfer certain funds to the Multiemployer Health Benefit Plan and the 1974 United Mine Workers of America Pension Plan, and for other purposes.

S. 184

At the request of Mr. WICKER, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 184, a bill to prohibit taxpayer funded abortions.

S.J. RES. 1

At the request of Mr. BOOZMAN, the names of the Senator from Arkansas (Mr. COTTON), the Senator from Iowa (Mrs. ERNST), the Senator from Maine (Mr. KING) and the Senator from Massachusetts (Ms. WARREN) were added as cosponsors of S.J. Res. 1, a joint resolution approving the location of a memorial to commemorate and honor the members of the Armed Forces who served on active duty in support of Operation Desert Storm or Operation Desert Shield.

S.J. RES. 6

At the request of Mr. MENENDEZ, the name of the Senator from Connecticut (Mr. MURPHY) was added as a cosponsor of S.J. Res. 6, a joint resolution proposing an amendment to the Constitution of the United States relative to equal rights for men and women.

S. CON. RES. 5

At the request of Mr. DAINES, the name of the Senator from Iowa (Mrs. ERNST) was added as a cosponsor of S. Con. Res. 5, a concurrent resolution affirming the importance of religious freedom as a fundamental human right that is essential to a free society and protected for all people of the United States under the Constitution of the United States, and recognizing the 231st anniversary of the enactment of the Virginia Statute for Religious Freedom.

S. RES. 6

At the request of Mr. RUBIO, the names of the Senator from Hawaii (Ms. HIRONO), the Senator from Rhode Island (Mr. WHITEHOUSE), the Senator from Washington (Ms. CANTWELL), the Senator from Maine (Mr. KING) and the Senator from Rhode Island (Mr. REED) were added as cosponsors of S. Res. 6, a resolution objecting to United Nations Security Council Resolution 2334 and to all efforts that undermine direct negotiations between Israel and the Palestinians for a secure and peaceful settlement.

S. RES. 15

At the request of Mr. LEE, the names of the Senator from Oklahoma (Mr. LANKFORD) and the Senator from Nebraska (Mrs. FISCHER) were added as cosponsors of S. Res. 15, a resolution expressing the sense of the Senate that the Mexico City policy should be permanently established.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. SCHUMER:

S. 187. A bill for the relief of Alemseghed Mussie Tesfamical; to the Committee on the Judiciary.

Mr. SCHUMER. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 187

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PERMANENT RESIDENT STATUS FOR ALEMSEGHED MUSSIE TESFAMICAL.

(a) IN GENERAL.—Notwithstanding subsections (a) and (b) of section 201 of the Immigration and Nationality Act (8 U.S.C. 1151) and section 240 of such Act (8 U.S.C. 1229a), Alemseghed Mussie Tesfamical shall be eligible for the issuance of an immigrant visa or for adjustment of status to that of an alien lawfully admitted for permanent residence upon filing an application for issuance of an immigrant visa under section 204 of such Act (8 U.S.C. 1154) or for adjustment of status to lawful permanent resident.

(b) ADJUSTMENT OF STATUS.—If Alemseghed Mussie Tesfamical enters the United States before the filing deadline specified in subsection (c), Alemseghed Mussie Tesfamical shall be considered to have entered into and remained lawfully in the United States and, if otherwise eligible, shall be eligible for adjustment of status under section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) as of the date of the enactment of this Act.

(c) DEADLINE FOR APPLICATION AND PAYMENT OF FEES.—Subsections (a) and (b) shall apply only if the application for issuance of an immigrant visa or for adjustment of status is filed by Alemseghed Mussie Tesfamical with appropriate fees not later than 2 years after the date of the enactment of this Act.

(d) REDUCTION OF IMMIGRANT VISA NUMBER.—Upon the granting of an immigrant visa or permanent residence to Alemseghed Mussie Tesfamical, the Secretary of State shall instruct the proper officer to reduce by 1, during the current or next following fiscal year, the total number of immigrant visas that are made available to natives of the country of Alemseghed Mussie Tesfamical's birth under section 203(a) of the Immigration and Nationality Act (8 U.S.C. 1153(a)) or, if applicable, the total number of immigrant visas that are made available to natives of such country under section 202(e) of such Act (8 U.S.C. 1152(e)).

(e) BUDGETARY EFFECTS.—The budgetary effects of this Act, for the purpose of complying with the Statutory Pay-As-You-Go Act of 2010 (Public Law 111-139), shall be determined by reference to the latest statement titled "Budgetary Effects of PAYGO Legislation" for this Act, submitted for printing in the Congressional Record by the Chairman of the Committee on the Budget of the Senate, provided that such statement has been submitted prior to the vote on passage.

By Mr. CASSIDY (for himself, Ms. COLLINS, Mrs. CAPITO, and Mr. ISAKSON):

S. 191. A bill to improve patient choice by allowing States to adopt market-based alternatives to the Affordable Care Act that increase access to affordable health insurance and reduce costs while ensuring important consumer protections and improving patient care; to the Committee on Finance.

Mr. CASSIDY. Mr. President, today I have the privilege, with Senator COLLINS, to introduce a replacement bill for ObamaCare, with her experience as an insurance commissioner and mine as a physician caring for the insured and the underinsured. Let me also give due credit to PETE SESSIONS in the House, who has introduced a very similar bill to come up with something that we think works not just for the people we represent but for the entire country. That is our goal.

I wish to speak on the Patient Freedom Act of 2017. Our goal, if you will—I tell my staff to imagine a woman who voted for Donald Trump and doesn't like ObamaCare, but she has breast cancer. Her coverage has a \$6,000 deductible, but she has coverage. On the other hand, she wants to see something different. If we just view our efforts through the prism of her care, I think we will do right by the American people.

Let me say something else. Again, our goal is not to come up with a Republican plan; it is not to come up with an anti-ObamaCare plan; our goal is to come up with an American patient plan where, whoever she or he is, they can feel comfortable that, as a Senate, we are trying to do right by the American people.

Let's go to first principles. First principles is, we in the Republican Party think that if you like your insurance, you should be able to keep it. I will come to that later. President Obama was rightly criticized because he pledged that, and it turns out it wasn't true. That is one of our first principles, and we mean it.

Secondly, we think the States should have the power, not the Federal Government. When you speak to Americans, they want their State capital to be the kind of principal force behind how their insurance is administered, not our Nation's Capital, so we return power to both the States and to patients.

Lastly, I will say that we are truly reaching out to Democrats. One of the criticisms of ObamaCare is that it was rammed through on a partisan vote with hardly a consideration given of Republicans. Senator COLLINS and I are absolutely open to working with Democrats for this solution.

How do we begin?

We first begin by repealing the ObamaCare mandates and penalties. The American people do not like Washington telling them how to live their lives. We take those mandates and penalties from both the individual and the employer and we take them off.

Secondly, we work to make health care truly affordable. We do this by giving States a choice to put in what we call the State alternative. I think we are going to begin calling it the better choice. In the better choice, we would use tax credits which would go to those who are eligible and which would go into an account. If the patient did nothing, she would have a

health savings account, which will be pre funded. The money would go in, actually put money into the account—catastrophic coverage and a pharmacy benefit.

It is important to note that she would have power over this account. If she wished, she could combine it with her family's, these different tax credits, and they could buy a richer family policy, or she could assign it to her employer as the employee's contribution for an employer-sponsored plan.

If each member of the family decided to keep their own HPSA account and one of them got a terrible illness and went into the cash portion and exhausted their health savings account, we would allow family members to donate their health savings account balance to each other to help cover that cash exposure.

We do different things, but the goal is to give the patient the power.

Since we are going to these health savings accounts under the better choice model, in the better choice model, we give these tax credits that go into a health savings account. The individual can donate their own money, or the employer can contribute theirs. These are some of the options they have, but whichever options they have, we institute price transparency. That is to say that when the patient goes to have her blood test, she will know the cost of the blood test before she has it done as opposed to finding out later.

This came to mind this past Sunday. I had a friend in town for the inauguration. She is a physician, and she went for a vitamin D level. When she went for the vitamin D level and got the bill, it was \$290. She called the hospital and said: I order these all the time. Am I really getting a \$290 charge on each of these?

They said: Oh, yes, ma'am. That is what we bill patients.

So she went to different labs and found out the cash price for the panels of labs she typically orders.

She had a patient who was from out of town and was paying cash. She said: Pay me \$38; it will cover the labs. Here is the slip; go to the lab.

The patient paid \$38 but went to the wrong laboratory. She was from out of town and not quite sure where to go. She went to the wrong laboratory. The bill she got, which in one lab would be \$38, in the other lab was \$690.

My physician friend called the hospital and said: You have to be kidding—\$690?

They reduced it to \$380. There is a tenfold difference in the cash price for labs. If the patient had known that, she probably would have paid more attention to the directions. But certainly if the price of the labs were posted when she went, even if she went to the wrong place, she could have looked at the fee schedule and decided she needed to go someplace else.

One of the young men who work with me said: Yes, I get it, price trans-

parency. Who would buy a car without knowing the price beforehand? It would be great for the car dealer but really lousy for you. That is how we purchase health care now. It is great for the folks selling the service; it is pretty lousy for the person paying the cash.

By this, we think we begin to use market forces to reduce costs. By the way, this is not only about saving the patient money, which is very important, but here is another example.

John Fleming is a physician who until recently was a Member of the House of Representatives. He tells the story of when their office went to a health savings account, a woman who worked with him came to him and said: Dr. Fleming, I don't like these health savings accounts. Previously I had a pharmacy benefit that paid for my inhaler, and now I don't have the same pharmacy benefit.

He said: Well, under their plan, at least, you can use the health savings account to pay for your inhaler, and, by the way, if you stopped smoking, you wouldn't need the inhaler.

Then he walks away.

Six months later she says to him: Dr. Fleming, you were right.

He didn't remember the conversation. He turns around and she says: Remember when you told me if I stopped smoking, I wouldn't need an inhaler? I stopped smoking and I don't need an inhaler.

So what this does is it activates the patient. It gets her or him engaged in their health care, and between that—not only do we protect the patient's pocketbook, but we also do something positive for their health care.

Let me also point this out. We think most States would go for the better choice. It is possible, though, that a State will reject everything and say: We don't want Medicaid expansion dollars and we don't want any extra help for those who have lower incomes. We would give States that choice. This is not Washington, DC, forcing something on people.

Let me also point out something else. Republicans believe that if you like your health care, you can keep it; if you like your health insurance, you can keep it, and we mean it. If a State decided they wished to stay on ObamaCare—I think it is a terrible decision—but this legislation would allow a State to do so.

I was so disappointed. I saw that the minority leader, Mr. SCHUMER, criticized our bill and said things that weren't true—fake news, if you will. He said we didn't cover preexisting conditions. We do. He said the deductibles and copays would be too high, which is not true, but what was striking is that he hasn't read our legislation yet.

This is what is wrong with Washington, DC. Here we have something which in good faith would allow New York to stay in ObamaCare if the people of New York decided they wished to—but we can look at double- and even triple-digit premium increases in

other States. Without reading our bill, other States are going to be condemned to these double- and triple-digit premium increases because folks don't want to consider something different. This is not a Republican plan. It is not a Democratic plan. We want it to be an American plan where States can decide the best system for their State, and if it is working for New York, it can stay in New York. It is not working for Louisiana so our State would go with the better choice, I am confident.

That said, please don't criticize the plan before you even look at it, and please allow those on the Democratic side who are down to one insurance company on their exchanges, with double-digit premium increases, to at least consider an option that would be good for their State.

Now, folks say: Well, you don't have a mandate. We don't think Washington, DC, should be telling people how to live their lives. So how do we, under our better choice, get the kind of big insurance pool without a mandate? We give States the option to do what we call automatic enrollment. If someone is eligible, they would be enrolled. The tax credit they receive would be adequate for their premium. They would never have to pay anything out-of-pocket to have this health savings account—high-deductible health plan and pharmacy benefit. It would be covered with the tax credit they receive. By doing so, all these young males who haven't signed up for ObamaCare because they are paying too much would actually be enrolled in an insurance plan. For those who get ill or have chronic conditions, they are spreading the cost of their expensive illness over the many healthy and not just over the few sick. It restores the law of big numbers.

We had an insurance plan model this, and they said they think just by doing our method of enrollment, it would lower premiums by 20 percent. That is without an individual mandate.

By the way, think of the folks who will never sign up for an ObamaCare exchange policy. The mentally ill person living beneath a bridge is not going to go to a public library. If he has his W-2 form, he doesn't know where it is. He is not going to fill out a 16-page, long-line form and sign up for ObamaCare. Under our policy, he could be automatically enrolled. So if he goes to the urgent care center with cellulitis, he has coverage. If something terrible happens—if he is hit by a car, and goes to the emergency room and is admitted to the hospital, society is protected from major expenses. If he gets his life together enough, he has a pharmacy benefit providing those antipsychotics. So we actually think we would increase the number who truly need health care to the number of those who are covered.

Let me finish up by speaking about our timeline. We hope that over this next year, Republicans and Democrats can come together. I understand Democrats will not vote for a reconciliation

bill that begins the repeal process of ObamaCare, but that almost certainly will pass. What we hope is that sometime within this year, Democrats who live in States with only one insurance company on their exchanges, in which premiums are increasing by double—and maybe even at that time in their States triple digits—will come together to vote with us to give their State an option for our better choice. So we would pass that legislation in 2017, giving their State legislatures and Governors the option to choose this pathway in 2018; and in 2019, the States would implement their option of choice; and by 2020, it has all been done.

That is our hope.

Folks say Senator COLLINS and I are naive; that the Senate cannot overcome its partisanship; that inevitably it will be so partisan, people, without reading the bill, will criticize our legislation, saying things about it that are not true.

I go back to where I started, to that woman who didn't go to college, working hard, voted for Trump, doesn't like ObamaCare but has breast cancer. She needs coverage, and she wants something done for her. We want to give her the power. We want to give her that coverage. My goal is that when this finishes, as she goes from cancer to health, the only thing she knows about her coverage is that the decisions about her health care are made in her State Capitol and around her kitchen table, and that as her breast cancer is treated, her health coverage improves. That is our goal. It is not a Democratic plan or a Republican plan. It is not a partisan plan. It is a plan for her. That is our goal.

Ms. COLLINS. Mr. President, first, let me commend the Senator from Louisiana for his extraordinary work on this bill. It has been a great pleasure to work so closely with him as we have made a genuine effort to put together a bill that would be a reasonable replacement for ObamaCare that would help to bring people together.

I wish to commend the Senator from Louisiana for his expertise. As a physician, Senator CASSIDY brings an important perspective to this debate, particularly since he has practiced for so many years in hospitals in Louisiana that serve the uninsured. So I wish to personally thank him for the privilege of working together to craft this bill.

There has been much debate recently on the best approach to replacing and reforming the Affordable Care Act. Considerable confusion and anxiety exists about the current status of the law and about the future of health care in our country. However, what is often overlooked in this discussion is that while the ACA provides valuable assistance for some people who were previously uninsured, the system created by the law is under tremendous financial strain.

ObamaCare exchanges are on the verge of collapse in many States. The

reality is that significant changes must be made. Doing nothing is not an option.

I am, therefore, both surprised and disappointed by the remarks of the Democratic leader to the press and on the floor today about the genuine effort that Senator CASSIDY and I have put forward in introducing the Patient Freedom Act.

First of all, let me point out that the Democratic leader could not possibly have read our bill since we haven't introduced it yet, and it is evident that he has misunderstood many of its provisions.

For example, in a press statement, he said we gutted the preexisting condition protections that we strongly support and that are codified in our bill in section 101(b). Again, that is section 101(b). It ensures that insurers cannot discriminate against individuals with preexisting conditions who pay their premiums.

I guess what disappoints me most is that the Democratic leader's response really represents what is wrong with Washington, DC. The American people want us to come together. They want Democrats and Republicans to work as a team to solve the problems facing our Nation. If we are going to have a leader on the other side of the aisle denounce to the press and come to the Senate floor to criticize a bill that has not even been introduced yet, where are we? I really hope this is an aberration and that we can work together and that the compromises we put in the bill are recognized as a good-faith effort to bring both sides of the aisle together in the interests of the American people and in providing access to affordable health care. That is our goal.

We are not saying our bill is perfect. We are open to refinements. We have made a good-faith effort, and to hear it described inaccurately and as other than a genuine effort to solve a problem truly disappoints me.

The fact is, the ACA has been in effect for years. Yet nearly 30 million Americans still do not have health insurance coverage. Many of those who do have coverage through the ACA exchanges are experiencing large spikes in premiums, deductibles, and copays, increasing costs to consumers and taxpayers alike. Contrary to the predictions made by the early supporters of the ACA, premiums are increasing in nearly every State, with an average increase of 25 percent nationally.

In New York State, the average increase on the exchange is 16.6 percent. I don't know, but perhaps the Democratic leader thinks that is an acceptable rate of increase. It strikes me as pretty high, and even though it is below the national average, it is still in double digits. The situation is even more dire in some States like Arizona, where premiums have increased by 116 percent. In many counties throughout our country, there are only one or two health insurers offering plans on the exchanges, severely limiting consumer choice.

In my State of Maine, premiums for the individual market for 2017 have soared by 22 percent, on average, and plan options have become more limited. Now, while subsidies do cushion the blow for those consumers who are eligible for them, others have had to shoulder the full increase, and of course taxpayers have borne a greater burden. Moreover, individuals and families with incomes exceeding 250 percent of the poverty rate are not shielded from the dramatic increases in deductibles and copays. That is important to remember. The premium subsidy applies to incomes up to 400 percent of the poverty rate. It then drops off the cliff, and you are eligible for no subsidy whatsoever—there is no orderly phaseout. For help with copays and deductibles under the Affordable Care Act, the threshold is 250 percent of the poverty rate. These huge premium spikes and increases in deductibles and larger copays are having an effect on families and individuals—who are by no means wealthy—all over this Nation.

Millions with coverage under the ACA are also facing increasingly narrow networks, which means they may find their preferred doctors are not in their networks. This can be particularly difficult for rural States that may have few specialists and whose citizens rely on major medical centers in nearby States. If patients want to continue to see these doctors, they can be faced with enormous costs that are not covered by their ACA insurance. As one Mainer put it, “[President] Obama said I could keep my doctor, and the insurance company says I can't.”

The co-ops created under the ACA to help provide health insurance coverage have been failing at an alarming rate. In fact, only 5 of the 23 remain operational. It is also important to carefully consider the effects that ObamaCare's Medicare cuts have had on providers like rural hospitals and home health agencies, many of whom are struggling.

In sum, prices are skyrocketing, coverage is narrowing, and the individual market is likely in a death spiral if Congress fails to act.

I know many Members of this Chamber share the goal of expanding access to affordable health care. Over the years, I have collaborated with colleagues on both sides of the aisle on a number of initiatives. Today I am pleased to join my colleague, Senator and Doctor BILL CASSIDY, in introducing the Patient Freedom Act of 2017 to help ensure that Americans have access to affordable health care that improves choices and helps to restrain costs.

Let me emphasize again that our bill is a work in progress. It is not perfect. However, what it does—and it is virtually unique in this regard, in this Chamber—is it puts specific proposals on the table as we seek to craft bills to repair and improve the Affordable Care Act. Other legislation being discussed,

such as those designed to help small businesses pool risks so they can better afford to provide insurance to their employees, also deserves consideration. Let's get a lot of ideas on the table.

We have to start, and we have been willing to step forward and propose a specific bill. To be criticized for that by the Democratic leader is just so disappointing, particularly since the leader is well aware that I work across the aisle all the time to try to find solutions for our country.

The Patient Freedom Act is built on the premise that giving people more choices is superior to the one-size-fits-all approach that defined the Affordable Care Act. We recognize that what works best for people in Maine or New Hampshire may not be right for people in New York or California. Our bill respects those differences by giving States options to choose the path that works best for their citizens.

Now, option one would allow a State to choose to continue operating its insurance markets pursuant to all the rules of the Affordable Care Act. So if New York State wants to keep with the status quo, despite the 16.6-percent increase, on average, in the premiums for the individual market, New York State can make that choice. If a State chooses to remain covered by the ACA, exchange policies will continue to be eligible for cost-sharing subsidies and advanced premium tax credits, and the insurance markets will still be subject to ACA requirements. The individual mandate and the employer mandate will also remain in place for that State. Medicaid expansion States will continue to receive Federal funding. So if a State is happy with the status quo—with spiraling costs, with limited choices, with a market that is broken—fine, keep the ACA. In some States, maybe it is working well. States should have that option, and they would under the Cassidy-Collins bill.

More appealing to many States, however, would be what we call the better choice option in the Patient Freedom Act that would allow a State to waive many of the requirements of the ACA, except for vital consumer protections, and still receive Federal funding to help its residents purchase affordable health insurance. Senator CASSIDY has explained how it would work so I will not go through that all again.

Let me just say that eligible individuals in States selecting this option would receive Federal funding deposited into their Roth health savings accounts. The aggregate funding for these per-beneficiary deposits would be determined based on the total amount of funding that the Federal Government would have provided in the form of ACA subsidies in each State, plus any funding each State would have received had it chosen to expand its Medicaid Program—even if, like my State, it has chosen not to do so. These deposits in the Roth health savings accounts would be phased out for higher income beneficiaries.

States selecting this option for every resident who does not have health insurance coverage through his or her employer or through public programs like Medicare or the VA or the Federal Employees Health Benefits Program—in those States, the option would be a standard health insurance plan that would include first-dollar coverage through the Roth health savings account, basic prescription drug coverage, and a high-deductible health plan. States could automatically enroll their residents who are uninsured in this standard plan, unless an individual opted to use his or her health savings account to purchase more comprehensive coverage or opted out of coverage altogether. I can't imagine someone making the choice of opting out altogether when they would receive this generous subsidy.

In addition to Federal funds, individuals and employers could make contributions to these health savings accounts, and the balances would grow tax-free. The bill also provides for a partial tax credit for very low-income individuals who do receive employer-based coverage to help these workers pay for their deductibles and their copays.

Here is another important provision of our bill: Health care providers receiving payments from the Roth health savings accounts would be required to publish cash prices for their services. That would add transparency that is sorely lacking in our current system and that we need to move toward a more patient-directed health care future. For example, if your physician has suggested that you have a colonoscopy, you would know whether one hospital or one clinic would charge more than another so you can make the right decision for you.

Health care reform should be about expanding affordable choices, and that is what our legislation aims to do by allowing States to structure their individual health insurance markets and to do so without the burdensome individual mandate, the employer mandate, or many of the other restrictive requirements in the ACA that have substantially driven up costs and forced millions of Americans to buy coverage that is more than they want, need, or can afford. Americans should have the choice to purchase more affordable coverage, if that is what works best for them.

Let me again emphasize, since misinformation was given to the press about the consumer protections in our bill, the Patient Freedom Act would retain several important consumer protections, contrary to what was said earlier today by a colleague who hadn't read our bill. Dependents will be able to remain on their parents' health insurance policies until age 26. Insurance companies will still not be able to exclude coverage for preexisting conditions or discriminate based on health status. In fact, there is no medical underwriting for the standard plan of-

fered under the better choice option. Insurance companies cannot cap benefits by including lifetime or annual limits in their policies, and they must offer to renew policies as long as enrollees continue to pay premiums. Insurance companies must also continue to cover mental health and substance use disorder benefits for individuals, a particularly important benefit given the nationwide scope of the opioid crisis that has seriously affected my State of Maine and so many other States throughout our country, ruining the lives of individuals, their families, and their communities.

Provisions like these vital consumer protections should be retained. However, the Washington centric approach of the ACA must be changed if we are ever to truly reform our broken health care system.

I am pleased to see a growing consensus among Members of both the Senate and the House that we must fix the Affordable Care Act and provide reforms at nearly the same time as we repeal the law. This will help protect the families who rely on the program and give insurers time to transition to a new marketplace that is based on more choices for consumers. That is what we are trying to do here. Reforms in the way we provide health insurance must ensure that individuals relying on the current system do not experience a needless and avoidable gap in coverage.

If we are going to reform the system, we must begin to put specific proposals on the table for our colleagues to debate, refine, amend, and enact. That is why the criticism is so disappointing. This is an attempt to put forth a possible solution that would appeal to Members on both sides of the aisle.

As we continue our work to find a responsible path to repealing and repairing the ACA, we should give the States the freedom to choose what they believe works best for their citizens, whether that means staying with the Affordable Care Act or selecting a different path—in my view, a better path—that will lead to patient-directed reforms that contain costs and provide more choice. The Patient Freedom Act does exactly that, and I commend my colleague Senator CASSIDY for his leadership on this legislation. I also want to thank our cosponsors, including Senator ISAKSON and Senator CAPITO for their support as well.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 18—RE-AFFIRMING THE UNITED STATES-ARGENTINA PARTNERSHIP AND RECOGNIZING ARGENTINA'S ECONOMIC REFORMS

Mr. COONS (for himself, Mr. RUBIO, Mr. Kaine, and Mr. Lankford) submitted the following resolution; which was referred to the Committee on Foreign Relations: